

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE OF DELAWARE
DEPARTMENT OF HEALTH
AND
SOCIAL SERVICES**

**SECTION 1864 – 1902 SURVEY AND
CERTIFICATION COSTS FOR HEALTH
CARE PROVIDERS AND SUPPLIERS**

OCTOBER 1, 1997 – SEPTEMBER 30, 1999



**JANET REHNQUIST
Inspector General**

**NOVEMBER 2001
A-03-00-00210**



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES

150 S. INDEPENDENCE MALL WEST

SUITE 316

PHILADELPHIA, PENNSYLVANIA 19106-3499

November 13, 2001

The Honorable Vincent P. Meconi, Secretary
Delaware Department of Health and Social Services
1901 North Du Pont Highway, Main Building.
New Castle, Delaware 19720

Dear Secretary Meconi:

This final audit report presents the results of an Office of Inspector General (OIG), Office of Audit Services (OAS) review of Survey and Certification (S&C) costs allocated to the Medicare and Medicaid certification, and State licensing programs in the State of Delaware. The objectives of the review were to determine whether S&C costs were allocated correctly among Medicare and Medicaid certification, and State licensing programs and whether Medicare and Medicaid costs claimed on the State Survey Agency Quarterly Expenditure Report (HCFA 435) were supported and claimed in accordance with Federal criteria pertinent to the State S&C agency. Our audit covered S&C costs reported to the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA) for Federal Fiscal Years (FYs) 1998 and 1999 (October 1, 1997 through September 30, 1999).

Prior to March 1999 the Delaware Department of Health and Social Services (DHSS), Division of Public Health (DPH), Office of Health Facilities Licensing and Certification handled all survey functions. In March 1999 the Division of Long Term Care Residents Protection (DLTCRP) was created within DHSS to oversee Long Term Care (LTC) facilities such as nursing homes. The responsible survey agencies are collectively referred to as the State Survey and Certification Agency (SA).

Based on our examination and analysis of financial information, supporting documentation and other available evidence, we found that the SA overcharged the Medicaid Program by \$155,321 in Federal Financial Participation (FFP) and undercharged Medicare by \$22,110. The Medicare undercharge was part of \$208,092 in costs that should have been allocated to Medicare instead of Medicaid. As the Medicare grant was capped, only \$22,110 that was not claimed for the 2-year period up to the capped amount is chargeable to Medicare as an allowable cost.

The SA did not have sufficient internal controls to ensure that the S&C costs for both Medicare and Medicaid were accurately and completely reported on the quarterly HCFA 435. Specifically, overcharges and undercharges resulted because the SA:

- L Allocated costs to certify LTC facilities on the basis of types of beds, which is specifically unallowable according to Sections 4544 and 4642 of the CMS State Operations Manual (SOM). The SOM requires costs to be allocated on a 50-50 basis when LTC facilities are certified for both Medicare and Medicaid. The incorrect allocation process resulted in an undercharge to Medicare of \$208,522, an overcharge to Medicaid of \$148,568 in FFP, and an overcharge to State Medicaid matching funds of \$59,954.
- L Overcharged the Medicare program by \$11,490 and the Medicaid program by \$6,316 in FFP for office space. This occurred because office space that was utilized by employees who performed non-survey functions or who were in other units was charged to S&C activities. As a result, \$17,806 was undercharged to other State accounts.
- L Overcharged the Medicare program by \$6,204 and the Medicaid program by \$5,115 in FFP for Ombudsmen salaries. This occurred because two persons employed as Ombudsmen in FY 1999 were charged to the S&C accounts instead of the Ombudsmen account. As a result, \$11,319 was undercharged to other State accounts.
- L Claimed unallowable Medicaid FFP for the Nurse Aide Registry (NAR) for FY 1998 in the amount of \$8,111. As a result, \$8,111 was undercharged to other accounts.
- L Undercharged FY 1999 Medicare costs of \$5,260, Medicaid FFP costs of \$2,892 and State Medicaid matching of \$2,891 for the Fire Marshal. This occurred because fiscal personnel posted the costs for one quarter of FY 1999 incorrectly to FY 2000.
- L Undercharged the Medicare and Medicaid programs in FY 1999 because they failed to properly charge \$12,004 to Medicare and \$9,897 in Medicaid FFP for salaries in June 1999. As a result, \$21,901 was overcharged to the other State accounts.

Additionally, the SA needed to improve internal controls over record retention and financial reporting. The SA did not retain all cost allocation records for the entire 3-year period as required by the 45 CFR 92.42(b) and did not file quarterly reports of expenditures timely for FY 1999.

We recommend that the SA:

1. Submit a revised HCFA 435 claim for the \$208,092 undercharge to Medicare. However, since the Medicare grant was capped, only \$22,110 that was allocated in the budgets but not claimed for FYs 1998 (\$133) and 1999 (\$21,977) is allowable for payment.
2. Refund to the Federal Government \$155,321 FFP in Medicaid funds inappropriately claimed for the SA programs. This includes:
 - L \$148,568 in FFP as a result of the failure to allocate costs in joint Medicare/Medicaid facilities on an equal basis;
 - L \$6,316 in FFP for office space;
 - L \$5,115 in FFP for Ombudsmen costs;
 - L \$8,111 claimed for the NAR;

The Medicaid refund should be offset by the following credits:

- L \$2,892 for Fire Marshal costs;
 - L \$9,897 for June 1999 salary charges.
3. Develop and implement a new Cost Allocation Plan that includes a method of allocating costs based on a 50/50 basis between Medicaid and Medicare when workers perform survey and certification activities for facilities that contain both Medicaid and Medicare beds to ensure that costs claimed after FY 1999 are appropriate.
 4. Improve internal controls to ensure that employee time is properly charged to the appropriate program; costs accumulated are charged to the appropriate program and FY; cost allocation records are retained for the required period and reports are filed timely.

By letter dated October 12, 2001, DHSS responded to a draft of this report. The DHSS generally agreed with our conclusions and recommendations concerning financial adjustments and made a number of changes to improve internal controls. The DHSS also provided additional information on the Cost Allocation Method, Ombudsman and Medicaid Services Nurse, and Financial Reporting areas that we have used in making appropriate revisions to our draft report. We have summarized the DHSS response along with our comments after the Conclusions and Recommendations section of the report. We have also included the DHSS response in its entirety as Appendix B of the report.

BACKGROUND

Oversight of healthcare providers and facilities is a shared Federal and State responsibility. The CMS defines the standards that facilities must meet to participate in the Medicare and Medicaid programs. Section 1864(a) of the Social Security Act and the 45 CFR 488.10 provide for the CMS to contract with States to assess whether covered facilities and programs such as hospitals, nursing homes and home health agencies meet these standards. The SA determines whether the providers of these services are in compliance with all applicable conditions for participation in the Medicare and Medicaid programs. Surveys of LTC facilities must be conducted on average once per year, but no less than once every 15 months at each Nursing Facility. Intermediate Care Facilities for the Mentally Retarded must be surveyed annually. There are differing time frames for non-LTC facilities. The Delaware SA conducted 119 surveys during our audit period.

OBJECTIVE

Our audit objectives were to determine whether: (1) the SA costs have been allocated correctly among Medicare, Medicaid, and the State licensing programs, and (2) whether Medicare and Medicaid costs claimed by the SA on the HCFA 435 for FY 1998 and FY 1999 were supported and claimed in accordance with Federal criteria pertinent to the State S&C agency.

SCOPE AND METHODOLOGY

We conducted our review in accordance with the Government Auditing Standards. Our audit covered S&C costs totaling \$1,884,044 that the State of Delaware claimed and allocated to the Medicare, Medicaid and State licensing programs during FYs 1998 and 1999. Our audit included tests and procedures that were considered necessary to meet the objectives of our review including obtaining an understanding of the SA's accounting system and internal controls. To accomplish our audit objectives, we reviewed background information and criteria applicable to Delaware's S&C program and performed extensive tests of time and attendance and payroll related information, invoices, cost distribution worksheets and other pertinent documentation maintained to support the claim. We performed a review of Delaware's cost allocation plan (CAP) on which the claim was based and evaluated the accounting system used to account for the costs incurred under the S&C program;

We performed our review primarily at the State S&C program offices in Wilmington, Delaware, the Governor Bacon Health Care Center in Delaware City, Delaware, and the DHSS fiscal offices in Dover, Delaware. We conducted our fieldwork from August 2000 to January 2001.

RESULTS OF REVIEW

Our review disclosed that the SA generally had support for the Medicare and Medicaid costs that were incurred and claimed on the HCFA 435 for FY 1998 and FY 1999. However, we identified costs that were:

- improperly allocated between Medicare and Medicaid;
- reported but not allowed by Federal criteria;
- reported in the wrong Fiscal Year; and
- not reported.

Our review disclosed that the SA incorrectly allocated costs among Medicare, Medicaid, and State licensing activities. Overall, we found that the SA overcharged the Medicaid Program by \$155,321 in FFP and undercharged Medicare by \$22,110.

The review also showed that the SA did not maintain an adequate system of internal control over the recording and reporting of office space, ombudsman payroll expense, NAR expense Fire Marshal costs and other salary expenses as well as record retention practices and financial reporting that violated Federal Policy.

Our recalculation of allowable costs, taking into account all of the exceptions noted in the report, is contained in Appendix A.

Cost Allocation Method

The method to allocate costs between Medicare, Medicaid, and State Licensing programs used by the SA and the SA's contractor did not meet Federal standards. The SA allocated costs to certify LTC facilities on the basis of types of beds (Beds Method), which is specifically unallowable according to the SOM, Sections 4642 F and 4544. The SOM requires costs to be allocated on a 50-50 basis (Equal Allocation Method) when LTC facilities are certified for both Medicare and Medicaid. The SA's incorrect allocation process resulted in an undercharge to Medicare of \$208,522 in FFP, an overcharge to Medicaid of \$148,568 in FFP, and an overcharge to State Medicaid Matching by \$59,954.

The SA did not have a Cost Allocation Plan until December 1, 1999 (made effective retroactive to July 1, 1999). The SA hired a Contractor who developed this plan and performed the actual cost distributions for the SA. The plan stated that for

non-licensing/certification activities, the SA would “Allocate to all licensed facilities using the distribution of Medicaid/Medicare/Other beds in the respective Facility.”¹ Under this methodology an employee surveying a nursing home with 90 Medicaid beds and 10 Medicare beds would have charged 90 percent of his or her time to the Medicaid program. The plan called for the Licensing and Certification Unit to use actual time charged for licensing and certification activities and does not describe how certification costs will be allocated between the Medicare and Medicaid programs. In actual practice, for the period covered by this audit, the SA allocated time based on the bed distribution in the specific facilities that were surveyed.

Section 4642 F of the SOM covering “Cost Sharing For Title XVIII/XIX Facilities” reads:

“The costs of a survey for a title XVIII/XIX Facility must be shared equally between Medicare and Medicaid (FFP applicable to title XIX) regardless of the number of beds assigned to each program. The requirements are the same for both Medicare and Medicaid. Consequently, both programs benefit from the survey.” (SOM §.4642 F)

Section, 4544, reads:

“The Federal share of the costs of the survey and certification activities and follow-up visits related to surveys of SNFs participating in both titles XVIII and XIX are to be divided equally by the two programs.” (SOM §.4544)

We reallocated the total LTC costs reported for the 2-year period by considering all the beds that are surveyed. To determine the Equal Allocation percentages, we counted all of the beds in the facilities that are surveyed by the SA, and developed the ratio of Medicare to Medicaid beds. We applied this ratio to the combined LTC costs for FYs 1998 and 1999.

Comparison of Long Term Care Costs Using the Equal Allocation and Beds Methods			
	Beds Method	Equal Allocation Method	Difference
1998 Medicaid FFP	\$449,540	\$368,798	\$80,742
1998 State Match	157,894	130,690	27,204
1998 Medicare	342,449	450,395	(107,946)
1999 Medicaid FFP	406,614	338,788	67,826
1999 State Match	158,044	125,294	32,750
1999 Medicare	329,337	429,913	(100,576)
Total	\$1,843,878	\$1,843,878	\$0

¹The Cost Allocation Plan amendment Number 00-1, effective 7/1/99 for the Department of Health and Social Services, page A-1.

The table above shows that the Beds Allocation method resulted in an undercharge to Medicare of \$208,522, an overcharge to Medicaid of \$148,568 in FFP, and an overcharge to State Medicaid Matching by \$59,954. Because the CMS awarded the SA a capped Medicare grant, only \$22,110 in costs that could have been charged to the grant is allowable for reimbursement.

Office Space

The SA overcharged the Medicare program by \$11,490 and the Medicaid program by \$6,316 in FFP for office space for one facility. This occurred because office space that was utilized by employees who performed non-survey functions or who were in other units was charged to the S&C program. As a result, \$17,806 was undercharged to other State accounts.

At the Mill Road facility in Wilmington, all of the office space cost was allocated to the S&C Program. Other functions unrelated to S&C activity occupying the space were not charged. We found 17 of 54 State employees working in the rental space who were not performing SA functions.

Further, the SA's charges for State Licensure efforts did not agree with the amounts on the employee time spreadsheets. For example, in October 1998, 39 percent of S&C employees worked on non-survey and certification tasks according to the employees' time sheets. However, only 5 percent of the office space was charged to non S&C activities. Additionally, the allocation of costs to Medicare and Medicaid was not made in accordance with the Equal Allocation method.

In its budget requests for FYs 1998 and 1999 the SA stated:

“As in the prior years, funds are requested for office space in Wilmington and Dover. Expenses are applied to each program element on a pro rata basis.”²

We recalculated the amounts that should have been charged to the Medicare and Medicaid programs in FY 1999. Our analysis resulted in the identification of overcharges to the Medicare (\$11,490) and the Medicaid (\$6,316) programs.

We did not estimate any amounts for FY 1998 because the SA did not maintain the necessary records.

²Narrative Budget Reports for FY 1998 and 1999, page 2 of each report.

Ombudsmen and Medicaid Services Nurse

The SA overcharged the Medicare program by \$6,204 and the Medicaid program by \$5,115 in FFP for salaries of 1 Ombudsmen and 1 Medicaid Services Nurse for a 3-month period. As a result, \$11,319 was undercharged to other State accounts.

The DLTCRP came into existence in March 1999 in response to State legislation. The plan was for the long-term care surveyors, a Deputy Attorney General, two Medicaid Services Nurses assigned to long-term care, and the Office of the Ombudsman to be placed in the DLTCRP. In the final implementation, DLTCRP received the two Medicaid Services Nurses, but did not receive its own Deputy Attorney General. Further, the transfer of the entire Ombudsman Office did not occur because of a prohibition in the Older Americans Act. The DLTCRP did receive a number of Ombudsman positions that were to function as investigators in the Division's Investigations Unit. These positions were not part of the Licensing and Certification Unit.

We reviewed of the "LTCRP Payroll Report July - September 1999" and found that salaries and fringe benefits totaling \$22,201 for two employees who were working in the Ombudsman and the Medicaid Services function had been charged to the SA program and were used to develop the percentages to charge costs among the Medicare, Medicaid, and State licensure programs.

We determined that the unallowable Medicare charge for these individuals was \$6,204 and the unallowable Medicaid FFP was \$5,115.

Nurse Aide Registry (NAR)

In FY 1998 the SA claimed unallowable Medicaid FFP totaling \$8,111 for the NAR in FY 1998. As a result, \$8,111 was undercharged to other accounts.

The 42 CFR 483.156 states that each State must establish and maintain a registry of nurse aides. The registry must contain information concerning allegations of abuse, neglect, or misappropriation of property by an individual wishing to serve in the capacity of a Nurse Aide.

The State Operations Manual states that:

"Expenses incurred for title XIX-only facilities for NAR/NATCEP are considered administrative costs and are to be reported on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form HCFA-64. There are no provisions in the survey and certification budgets for these expenses."
(SOM, § 4543)

Therefore the \$8,111 in FFP charged to the S&C program for Medicaid in FY 1998 violated Federal criteria. We did not subject these expenses to the Equal Allocation method, as they were clearly not intended as Medicaid costs to be reported on the HCFA 435.

Fire Marshal

The SA incorrectly recorded FY 1999 fourth quarter contracted Fire Marshal costs. The Fire Marshal billed the SA for \$12,303. However, only \$11,043 remained in the contract. By applying the Equal Allocation method to these costs, we calculated that the SA failed to charge Medicare in the amount of \$5,260, Medicaid FFP of \$2,892 and State Medicaid Matching of \$2,891. These costs for the Fire Marshal were incurred in FY 1999 but were not recorded or claimed during FY 1999. Instead, the SA charged the costs to FY 2000. This is not permitted. The SOM cites specific requirements for the reporting of these expenses in the quarter in which they were incurred:

“Consultants, and Subcontracts.--The entries should cover total expenditures in each of these categories for the quarter covered by the report.” (SOM §.4760) Also,

“Consultants and Subcontracts.--The SA enters total expenditures in each of these categories for the quarter covered by the report.” (SOM §.4766)

The 45 CFR 74.21 (b)(6) (Standards for Financial Management Systems) and 45 CFR 74.28 (Period of Availability of Funds) requires that costs be incurred during the funding period. The OMB Circular A-87, Attachment A, made applicable to HHS grants by 45 CFR 74.27 (Allowable Costs) states that costs may not be shifted to other Federal awards to overcome funding deficiencies.

Medicare Salary Expenses in June 1999

The SA failed to properly charge \$12,004 to Medicare and \$9,897 in Medicaid FFP for salaries for the month of June 1999 because payroll expenses were improperly posted. As a result, State funds totaling \$21,901 were used to pay expenses that should have been charged to the Medicare and Medicaid program.

Records Retention

Internal Controls over the retention of records need to be improved. The SA failed to retain cost allocation records for the three-year period as required by the Code of Federal Regulations. Specifically, cost allocation source documents including time sheets were not available for FY 1998.

The OMB Circular A-87 addresses time records:

“Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation.”³

The 45 Code of Federal Regulations addresses record retention. It states:

“Retention and access requirements for records. (b) Length of retention period. (1) Except as otherwise provided, records must be retained for three years from the starting date specified in paragraph (c) of this section.” (45 CFR 92.42(b))

The referenced paragraph “c” reads:

“(c) Starting date of retention period-- (1) General. When grant support is continued or renewed at annual or other intervals, the retention period for the records of each funding period starts on the day the grantee or subgrantee submits to the awarding agency its single or last expenditure report for that period.” (45 CFR 92.42(c))

Although we did not question any costs based on lack of records, this practice violates Federal criteria. Since the Delaware Controller signed the final Form 435 for FY 1998 on December 30, 1998, the records should have been maintained at least until December 30, 2001.

Financial Reporting

The SA did not have sufficient internal controls for preparing the HCFA 435 to ensure that the costs were accurately reported quarterly for the Medicare and Medicaid programs. The SA did not file these quarterly reports of expenditures on a timely basis. The reports for FY 1999 (which ended on September 30, 1999) were dated July 11, 2000. This is contrary to the SOM, which reads:

“The purpose of Form HCFA-435 ... is to report in a categorical listing the expenditures for each quarter and to separate the costs according to funding source ... one form needs to be prepared quarterly.” (SOM § 4760 and 4766).

“The SA is required to submit Form HCFA-435/434 to the RO to be received no later than 45 days after the close of each quarter.” (SOM § 4740).

³Office of Management and Budget (OMB) Circular A-87, Attachment B, Section 11-h (4): "Support of Salaries and Wages."

In addition, the application for grants was not based on the 50-50 Equal Allocation Basis. As a result, budgets submitted for Medicare expenditures fell short of the amounts needed by \$185,982 (the \$208,092 identified by the report minus the \$22,110 in grant funds that can be claimed). If the SA had used the Equal Allocation method for cost computations in developing the Medicare budgets, the grant application would have reflected the correct split between Medicare and Medicaid funding needs. The grant application would have shown a higher amount of Medicare funds needed. Because the SA did not use the Equal Allocation method in preparing its budget, the SA did not have sufficient Medicare funds to cover its Medicare expenditures after the error was discovered during the grant year.

CONCLUSIONS AND RECOMMENDATIONS

Our review disclosed that the SA generally had support for the Medicare and Medicaid costs that were incurred and claimed on the HCFA 435 for FY 1998 and FY 1999. However, we identified costs that were:

- improperly allocated between Medicare and Medicaid;
- reported but not allowed by Federal criteria;
- reported in the wrong Fiscal Year; and
- not reported.

Additionally, the SA needed to improve internal controls over record retention and financial reporting. The SA did not retain all cost allocation records for the entire 3-year period as required by the 45 CFR 92.42(b) and did not file quarterly reports of expenditures timely for FY 1999.

We recommend that the SA:

1. Submit a revised HCFA 435 claim for the \$208,092 undercharge to Medicare. However, since the Medicare grant was capped, only \$22,110 that was allocated in the budgets but not claimed for FYs 1998 (\$133) and 1999 (\$21,977) is allowable for payment.
2. Refund to the Federal Government \$155,321 FFP in Medicaid funds inappropriately claimed for the SA programs. This includes:

L \$148,568 in FFP as a result of the failure to allocate costs in joint Medicare/Medicaid facilities on an equal basis;

L \$6,316 in FFP for office space;

L \$5,115 in FFP for Ombudsmen costs;

L \$8,111 claimed for the NAR;

The Medicaid refund should be offset by the following credits:

L \$2,892 for Fire Marshal costs;

L \$9,897 for June 1999 salary charges.

3. Develop and implement a new Cost Allocation Plan that includes a method of allocating costs based on a 50/50 basis between Medicaid and Medicare when workers perform survey and certification activities for facilities that contain both Medicaid and Medicare beds to ensure that costs claimed after FY 1999 are appropriate.
4. Improve internal controls to ensure that employee time is properly charged to the appropriate program; costs accumulated are charged to the appropriate program and FY; cost allocation records are retained for the required period and reports are filed timely.

DHSS RESPONSE AND OIG COMMENT

By letter dated October 12, 2001, DHSS responded to a draft of this report. The DHSS generally agreed with the conclusions and recommendations presented in the report and made a number of changes to improve internal controls. The DHSS will also submit a revised HCFA-435 report for the Medicare undercharge and acknowledges that a Medicaid overcharge occurred as the result of using the wrong methodology to allocate costs for dually certified facilities. The DHSS also provided additional information on the Cost Allocation Method, Ombudsman and Medicaid Services Nurse Charges, and Financial Reporting areas that we have used in making appropriate revisions to the report.

We believe that the actions completed or proposed by DHSS in response to our draft report represent positive steps to correct the noted deficiencies and maintain the overall quality of the Medicare and Medicaid survey and certification activity.

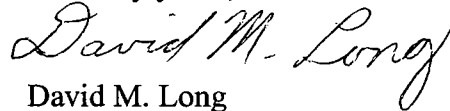
Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Page 13 – The Honorable Vincent P. Meconi, Secretary

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, HHS/OIG Office of Audit Services reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-03-00-00210 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in cursive script that reads "David M. Long".

David M. Long
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Steven McAdoo, Acting Regional Administrator
Centers for Medicare and Medicaid Services, Region III
Public Ledger Building Suite 216
150 S. Independence Mall West
Philadelphia, Pennsylvania 19106-3499

Appendix A

Comparison of Long Term Care Costs Claimed by SA to OIG Calculation			
Cost Category	SA Costs Claimed	OIG Calculation	Difference
FY 1998 Medicare	\$342,449	\$450,395	\$107,946 ¹
FY 1999 Medicare	\$329,337	\$429,483	\$100,146 ²
Total Medicare	\$671,786	\$879,878	\$208,092
FY 1998 Medicaid FFP	\$449,540	\$360,687	\$(88,853) ³
FY 1999 Medicaid FFP	\$406,614	\$340,146	\$(66,468) ⁴
Total Medicaid FFP	\$856,154	\$700,833	\$(155,321)
FY 1998 State Share	\$157,894	\$138,801	\$(19,093)
FY 1999 State Share	\$158,044	\$129,627	\$(28,417)
Total State Share	\$315,938	\$268,428	\$(47,510)

¹From Equal Allocation \$107,946

²From Equal Allocation \$100,576
 Minus Ombudsmen \$6,204
 Minus office space \$11,490
 Plus Fire Marshal \$5,260
 Plus Salary June 1999 \$12,004
 Total \$100,146

³From Equal Allocation \$80,742
 Plus NAR \$8,111
 Total \$88,853

⁴From Equal Allocation \$67,826
 Plus Ombudsmen \$5,115
 Plus Office Space \$6,316
 Minus Fire Marshal \$2,892
 Minus Salary June 1999 \$9,897
 Total \$66,468



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF
LONG TERM CARE RESIDENTS PROTECTION

15

October 12, 2001

Common Identification Number A-03-00-00210

Mr. David M. Long
Regional Inspector General
for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
150 S. Independence Mall West, Suite 316
Philadelphia, PA 19106-3499

Dear Mr. Long:

Thank you for the opportunity to comment on the draft audit report entitled "DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES SECTION 1864 – 1902 SURVEY AND CERTIFICATION COSTS FOR HEALTH CARE PROVIDERS AND SUPPLIERS," issued August 2001. I am responding on behalf of Secretary Vincent P. Meconi, Secretary of Delaware Health and Social Services (DHSS), to whom the cover letter and draft audit report were addressed.

The draft audit report pertains to the Medicare and Medicaid Survey and Certification costs for the periods of federal fiscal year (FY) 1998 and FY 1999, for the State Survey and Certification Agency (SA). DHSS, through the Division of Public Health (DPH) and the Division of Long Term Care Residents Protection (DLTCRP), is the SA for Delaware. Prior to March 1999, DPH surveyed and certified both non-long term care and long term care facilities. As of March 1999, with the creation of DLTCRP, that agency took over responsibility for long term care facilities.

Enclosed are the Department's comments on the draft report. The comments include those of both DLTCRP and DPH, for their respective time periods of responsibility for the Survey and Certification Grants covered by the audit.

Mr. David M. Long
October 12, 2001
Page 2 of 2

Again, we appreciate being able to respond to the draft audit report. If you have any questions regarding our response, please do not hesitate to contact me.

Sincerely,


Carol Ellis
Director

Enclosure

cc: The Honorable Vincent P. Meconi, Secretary, DHSS
Ulder Tillman, M.D., Director, DPH



DELAWARE HEALTH AND SOCIAL SERVICES

**RESPONSE TO THE DRAFT AUDIT REPORT
BY THE OFFICE OF INSPECTOR GENERAL, OFFICE OF AUDIT SERVICES
ISSUED AUGUST 2001
PERTAINING TO MEDICARE AND MEDICAID SURVEY AND
CERTIFICATION COSTS
FOR FEDERAL FISCAL YEARS 1998 AND 1999**

October 12, 2001

Below are comments by Delaware Health and Social Services (DHSS) regarding the draft audit entitled "Section 1864 – 1902 Survey and Certification Costs for Health Care Providers and Suppliers" (issued August 2001). DHSS, through the Division of Public Health (DPH) and the Division of Long Term Residents Protection (DLTCRP), is the State Survey and Certification Agency (SA). The comments are given by section, beginning with the "Results of Review" section of the draft audit report.

RESULTS OF REVIEW section (p. 4 of the document)

Cost Allocation Method subsection (p. 5 of the document)

- Referring to the DHSS/DLTCRP Public Assistance Cost Allocation Plan (PACAP) amendment approved by the Department of Health and Human Services in December 1999 and effective retroactive to July 1, 1999, the second paragraph of the draft report states that "The plan stated that the SA would 'Allocate to all licensed facilities using the distribution of Medicaid/Medicare/Other beds in the respective Facility.'"

Comment. This statement refers to the wrong cost allocation method. The sentence in the draft audit report erroneously attributes the methodology cited above to the Licensing/Certification Unit of the Division. However, this sentence in the PACAP does **not** refer to the cost allocation method to be used for costs associated with licensing/certification activities. This sentence in the PACAP pertains to the method used to allocate the costs of several non-licensing/certification sections of the Division. Further, even if the referenced methodology did refer to licensing/certification activities, the sentence quoted from the PACAP and cited above was followed by another sentence that stated that "Dually certified beds (i.e., Medicaid/Medicare) will be distributed equally between the two programs."

For the Licensing and Certification Unit, the PACAP gave the following method for charging costs associated with that Unit:

“Costs will be claimed in accordance with the Health Facilities Licensing and Certification Grant awarded by the Health Care Financing Administration (HCFA), USDHHS. Licensing and certification/survey effort associated with the grant award is supported by timesheets maintained by employees to record their effort on a daily basis. Effort is identified between licensing, certification/survey, and investigative activities by benefiting facility” (p. A-1 of the PACAP).

The PACAP effective July 1, 1999 clearly stated that the Licensing/Certification costs were to be claimed in accordance with the HCFA (now Centers for Medicare & Medicaid Services, or “CMS”) grant. DHSS therefore requests that the whole second paragraph in the draft report be either deleted from the final report or corrected to say that, according to the PACAP, costs associated with the licensing and certification activities were to be allocated in accordance with the HCFA/CMS grant.

Attachment 1 gives the relevant pages describing the cost allocation method to be used for the Licensing and Certification Unit from the PACAP effective July 1, 1999.

Ombudsmen subsection (p. 7)

- The first and third paragraphs of the draft state that the SA overcharged Medicare and Medicaid for the salaries of 2 Ombudsmen for a 3-month period, from July – September 1999.

Comment. In the Audit Fieldwork Closeout Conference report and in the meeting of February 7, 2001 with the auditors and DLTCRP, DLTCRP was given the names of the two employees. One employee named was an Ombudsman. However, the other employee was actually a Medicaid Services Nurse. For accuracy, a suggestion is to change these paragraphs to say 1 Ombudsman and 1 Medicaid Services Nurse, rather than 2 Ombudsmen. The heading of the section should perhaps also be changed to reflect this correction.

- The second paragraph of this section refers to a number of different functions and positions that were originally to be placed in the newly created DLTCRP, including “long-term care surveyors, the Deputy Attorney’s General, the Medicaid State authorities, and the Office of the Ombudsman.”

Comment. The wording of this paragraph is not quite accurate. There was no plan to merge the functions of “Deputy Attorney’s General and the Medicaid State authorities” into the new Division of Long Term Care Residents Protection. DLTCRP was to receive one Deputy Attorney General and two Medicaid Services Nurses. Further, DLTCRP did actually receive the two Medicaid Services Nurse positions, although the Division did not receive its own Deputy Attorney General.

We suggest that the wording be changed to the following, beginning with the second sentence:

“The plan was for the long-term care surveyors, a Deputy Attorney General, two Medicaid Services Nurses assigned to long-term care, and the Office of the Ombudsman to be placed in DLTCRP. In the final implementation, the Division received the two Medicaid Services Nurses, but the Division did not receive its own Deputy Attorney General. Further, the transfer of the entire Ombudsman Office did not occur because of a prohibition in the Older Americans Act. DLTCRP did receive a number of Ombudsman positions that were to function as investigators in the Division’s Investigations Unit. These positions were not part of the Licensing and Certification Unit.”

Financial Reporting subsection (p. 10)

- In the second paragraph, the last sentence says “...the excess Medicare expenditures may have been minimized or prevented.”

Comment. The last sentence is not clear. Is the word “Medicare” supposed to be “Medicaid”? At the Audit Fieldwork Closeout Conference on February 7, 2001, DLTCRP staff members understood the auditors to be saying that if the SA had used the Equal Allocation method for allocating costs between Medicare and Medicaid, the agency would have had accurate figures for determining the Medicare and Medicaid funds needed for the subsequent year’s grant application. The Medicare funds requested would have been higher, if the SA had been using the Equal Allocation method.

We request that the wording of the last sentence be changed to make it clearer. One suggestion for rewording is the following:

“If the SA had used the Equal Allocation method for cost computations in developing the Medicare budgets, the grant application would have reflected the correct split between Medicare and Medicaid funds needs. The grant application would have shown a higher amount of Medicare funds needed. Because the SA did not use the Equal Allocation method in preparing its budget, the SA did not have sufficient Medicare funds to cover its Medicare expenditures after the error was discovered during the grant year.”

CONCLUSIONS AND RECOMMENDATIONS section (p. 11)

(Please note that the draft report also lists the recommendations on pages 2 and 3 of the document. Any changes made in the final audit report based on the responses below would also have to be made on those pages.)

- 1. Submit a revised HCFA 435 claim for the \$208,092 undercharge to Medicare. However, since the Medicare grant was capped, only \$22,110 that was allocated in the budgets but not claimed for FYs 1998 (\$133) and 1999 (\$21,977) is allowable for payment.**

Response: As the draft audit report has pointed out, the undercharge to Medicare primarily resulted from using an incorrect methodology to allocate costs between Medicare and Medicaid for dually certified facilities. The budgets submitted to HCFA (now CMS) for both FY 1998 and FY 1999 and the subsequent grant awards, as well as the expenditure reports for those grant years, reflected the incorrect methodology.

The SA will submit revised HCFA-435 expenditure reports to CMS for FY 1998 and FY 1999, to claim the \$22,110. DLTCRP has contacted the CMS Regional Office fiscal person to see if these Medicare funds would be available. DLTCRP was told by the contact person to submit the 435s covering the audit findings, and then CMS would determine if there would be funds available to cover the expenditures.

In the event that the funds are no longer available from CMS to recode the costs to Medicare, we believe that the SA should be allowed to deduct the \$22,110 that is owed to the SA from the \$155,321 that the SA allegedly owes the Federal government (see #2, below).

- 2. Refund to the Federal Government \$155,321 FFP in Medicaid funds inappropriately claimed for the SA programs. This includes:**

- \$148,568 in FFP as a result of the failure to allocate costs in joint Medicare/Medicaid facilities on an equal basis;
- \$6,316 in FFP for office space;
- \$5,115 in FFP for Ombudsmen costs;
- \$8,111 claimed for the NAR;

The Medicaid refund should be offset by the following credits:

- \$2,892 for Fire Marshal costs;
- \$9,897 for June 1999 salary charges.

Response. As shown in the draft audit report, the amount of \$155,321 represents the net amount overcharged in Medicaid FFP for FY 1998 and FY 1999, combined, after the credit totaling \$12,789 is deducted. Of the \$155,321, the draft audit report showed that \$88,853 is from FY 1998 and \$66,468 is from FY 1999. As with the Medicare undercharge, the error was primarily the result of using the wrong methodology to allocate costs for dually certified facilities. The budgets submitted to HCFA (now CMS) for FY 1998 and FY 1999 and the subsequent grant awards reflected the incorrect methodology.

Since the Medicare funds are capped, as noted in the draft audit report, the State will not be able to charge Medicare for the funds incorrectly charged to Medicaid, except for \$22,110 that the auditors reported as remaining in the Medicare grants. The State will therefore have to pay the amount overcharged to Medicaid from its State general funds. DLTCRP is working with the fiscal people in the Department to determine how to recode the expenditures incorrectly charged to Medicaid. However, as stated in response #1 above, if the \$22,110 in Medicare funds is no longer available, we believe that the SA should be allowed to deduct the \$22,110 that is owed to the SA in Medicare funds from the \$155,321 that the SA allegedly owes the Federal government.

3. **Develop and implement a new Cost Allocation Plan that includes a method of allocating costs based on a 50/50 basis between Medicaid and Medicare when workers perform survey and certification activities for facilities that contain both Medicaid and Medicare beds to ensure that costs claimed after FY 1999 are appropriate.**

Response. DHSS requests that this recommendation be deleted, since it is based on an incorrect reading of the PACAP by the auditors.

As pointed out in the response to the Cost Allocation Method section of the draft audit report, the Cost Allocation Plan is not wrong as it pertains to survey/certification activities and therefore does not need to be changed. The Cost Allocation Plan, or PACAP, effective July 1, 1999 stated that costs associated with licensing and certification activities were to be claimed in accordance with the Survey and Certification Grant awarded by HCFA (now CMS). The Plan amendment, effective March 1, 2000, has the same wording (see Attachment 2).

The SA's error was that it did not follow the requirements of the State Operations Manual as it pertains to the Survey and Certification Grant, in allocating the costs associated with surveying and certifying facilities having both Medicare and Medicaid beds. DLTCRP corrected the problem and is splitting the costs for survey/certification activities for dually certified facilities equally between Medicare and Medicaid, as of FY 2000.

Beginning with the FY 2001 grant application, the survey/certification grant budgets also now show the correct funding split between Medicare and Medicaid for dually certified facilities. As a result of using the correct (Equal Allocation) methodology, the Medicare share of the grant budgets and of the expenditures has increased considerably relative to the Medicaid share, when compared to the FY 1999 budget.

In phone conversations with the CMS Regional Office fiscal contact person regarding the FY 2001 application, DLTCRP staff had pointed out the increase in the Medicare share of the budget. DLTCRP staff explained that the increase in the Medicare share

was the result of now using the correct, Equal Allocation methodology for dually certified facilities.

4. Improve internal controls to ensure that employee time is properly charged to the appropriate program; costs accumulated are charged to the appropriate program and FY; cost allocation records are retained for the required period and reports are filed timely.

Response. The SA has made a number of changes to improve its internal controls, as follows:

- Employee time and costs are being correctly charged to the appropriate program/funding source and the correct fiscal year, as of FY 2000, for all sections of DLTCRP.
- The methodology for splitting grant costs between Medicare and Medicaid for dually certified facilities has been corrected to be in compliance with the State Operations Manual and to be in keeping with the Cost Allocation Plan, as of FY 2000, as noted above.
- For the specific positions mentioned in the audit report, the following changes have been made: 1) the Ombudsman position is not being coded to the grant, effective FY 2000; 2) the Medicaid Services Nurse position has not been coded to the grant, effective FY 2000; 3) the NAR position has not been included in the Medicaid expenditures under the grant, as of FY 1999; 4) the Fire Marshal's costs are being charged to the grant year in which the expense occurred, effective immediately. Also, DLTCRP is in the process of correcting the coding for the final quarter of FY 2000, because the same procedure was used for coding the final quarter's salary for the Fire Marshal position in that fiscal year. DLTCRP will submit a revised HCFA-435 expenditure report for that quarter and a revised cumulative report.
- Records related to the allocation of costs, including time sheets, are being retained for the required three-year period, as of FY 1999.
- Expenditure reports are now being filed on a timely basis, in compliance with the State Operations Manual.

Attachments (2)

ATTACHMENT 1

STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF LONG TERM CARE RESIDENTS PROTECTION
PUBLIC ASSISTANCE COST ALLOCATION PLAN

Requested Effective Date July 1, 1999

Prepared by DMG-MAXIMUS, INC.
1280 West Peachtree Street, Suite 200
Atlanta, Georgia 30309

Medicaid Quality Review - The Medicaid Quality Review staff was transferred from the Division of Social Services. The nurses in the unit conduct reimbursement and quality of care reviews for Medicaid recipients. Each patient in every Delaware Medicaid participating nursing facility is assessed to determine the degree of nursing care needed by the patient. The assessment is entered into an automated system that determines the payment level for each resident. Staff conducts records reviews, personally observe and interview each resident, and meet with facility caregivers and family/representatives to discuss and identify any quality of care issues.

Programs Benefited

Medicaid
Medicare
State

Titles in Licensing and Certification Unit (including but not limited to)

Health Facilities Certification Administrator
Senior Secretary
General Administrative (seasonal)
Data Entry Technician
Management Analyst II
Compliance Nurse Supervisor
Compliance Nurse
Pharmacist Compliance Officer
Nutritionist III
Nutritionist II
Environmental Health Specialist III
Environmental Health Specialist II
Environmental Health Specialist I

Titles in Medicaid Quality Review Unit (including but not limited to)

Medical Services Nurse

Cost Allocation Method

Licensing and Certification Unit - Method E

Medicaid Quality Review Unit - Method A

Delaware DHSS Division of Long Term
Care Residents Protection
Public Assistance Cost Allocation Plan
Effective 7/1/99

Titles in Adult Abuse Registry Unit (including but not limited to)

Administrative Assistant II
General Administrative (seasonal)
Typist/Steno (seasonal)

Cost Allocation Method

Investigations & Protection Section Administration – Method C

Criminal Background Checks - Method F

Abuse/Neglect - Method D

Adult Abuse Registry - Method F

LICENSING AND CERTIFICATION SECTION

Purpose and Function:

The Licensing and Certification Section is comprised of two units. The Licensing and Certification Unit has overall administrative responsibility for state licensure and Medicare/Medicaid certification of long term care facilities. The other unit has responsibility for Medicaid quality review.

Licensing and Certification: The licensing and certification function for long term care facilities was transferred from the Division of Public Health (DPH). Other non-long term care facility state licensure and Medicare/Medicaid certification remain with DPH. Specifically, the DLTCRP has responsibility to conduct surveys for state licensure of rest (family care) homes, group homes for the mentally ill, intermediate care nursing homes, intermediate care facilities for the mentally retarded, group homes for the mentally retarded, neighborhood homes for the mentally retarded, Nurse Aide/Nurse Assistant certification, rest (residential) facilities, skilled nursing homes, assisted living agencies, and group homes for persons with AIDS. Medicare/Medicaid certification is conducted for intermediate care facilities for the mentally retarded, nursing facilities and skilled nursing facilities. The Licensing and Certification Unit is also responsible for administration of the Certified Nurse Assistant Registry contract.

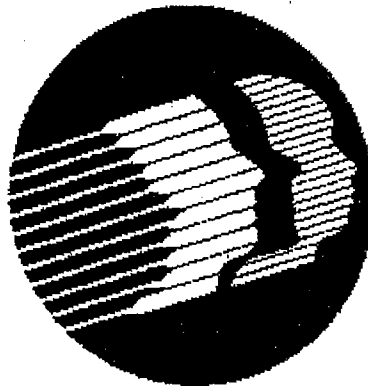
APPENDIX A

COST ALLOCATION METHODS

- A. Direct charge to Medicaid. In the case of Skilled Medical Professionals, costs are charged at the enhanced rate of 75% Federal Financial Participation (FFP).
- B. Allocate Division-wide based on filled positions identified to each organization unit.
- C. Allocate to organization units supervised using the filled positions identified to each organization unit.
- D. Allocate based on timesheets maintained by employees by benefiting facility. Employees record their effort on a daily basis. Effort is identified to investigative activities by benefiting facility. The total effort identified to investigative activities are allocated based on the distribution of Medicaid/Medicare/Other beds identified to the benefiting facilities. Dually certified beds (i.e., Medicaid/Medicare) will be distributed equally between the two programs. In the case of Skilled Medical Professionals, costs will be claimed at the enhanced rate of 75% FFP. Any effort identified to the general support of licensing and certification surveys will be allocated to the Licensing and Certification Section.
- E. Costs will be claimed in accordance with the *Health Facilities Licensing and Certification* Grant awarded by the Health Care Financing Administration (HCFA), USDHHS. Licensing and certification/survey effort associated with the grant award is supported by timesheets maintained by employees to record their effort on a daily basis. Effort is identified between licensing, certification/survey, and investigative activities by benefiting facility.
- F. Allocate to all licensed facilities using the distribution of Medicaid/Medicare/Other beds in the respective facilities. Dually certified beds (i.e., Medicaid/Medicare) will be distributed equally between the two programs.

STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF LONG TERM CARE RESIDENTS PROTECTION
AMENDMENT TO THE
PUBLIC ASSISTANCE COST ALLOCATION PLAN

Requested Effective Date of March 1, 2000



Prepared by DMG-MAXIMUS, INC.
1280 West Peachtree Street, Suite 130
Atlanta, Georgia 30309

Delaware DHSS Division of Long Term
Care Residents Protection
Public Assistance Cost Allocation Plan
Effective 3/1/00

Titles in Licensing and Certification Unit (including but not limited to)

Health Facilities Certification Administrator
Senior Secretary

Secretary

General Administrative (seasonal)

Data Entry Technician

Management Analyst II

Professional Social Work

Compliance Nurse Supervisor

Compliance Nurse

Pharmacist Compliance Officer

Nutritionist III

Nutritionist II

Environmental Health Specialist III

Environmental Health Specialist II

Environmental Health Specialist I

~~Titles in Medicaid Quality Review Unit (including but not limited to)~~

~~Medical Services Nurse~~

Cost Allocation Method

Licensing and Certification Unit - Method E

~~Medicaid Quality Review Unit - Method A~~

Titles in Criminal Background Checks Unit (including but not limited to)

~~Internal Affairs Supervisor~~
Internal Affairs Investigator
Administrative Assistant I

Titles in Centralized Complaints Section (including but not limited to)

Omb. Supervisor
Omb. Ad. Lt. Cr.
General Administrative
~~Advocacy Educator Chief~~
~~Social Services Administrator~~
~~Secretary~~
~~Resident Advocate Supervisor~~
~~Resident Advocate/Intake Investigator~~

Titles in Abuse/Neglect Unit (including but not limited to)

Exempt Special Investigator
Compliance Nurse Practitioner

Titles in Adult Abuse Registry Unit (including but not limited to)

Administrative Assistant II
General Administrative (seasonal)
Typist/Steno (seasonal)

Cost Allocation Method

Investigations & Protection Section Administration – Method ~~G~~ F

Centralized Complaints – Method F

Criminal Background Checks - Method F

Abuse/Neglect - Method ~~D~~ F

Adult Abuse Registry - Method F

APPENDIX ACOST ALLOCATION METHODS

- ~~A. Direct charge to Medicaid. In the case of Skilled Medical Professionals, costs are charged at the enhanced rate of 75% Federal Financial Participation (FFP).~~
- B. Allocate Division-wide based on filled positions identified to each organization unit.
- ~~C. Allocate to organization units supervised using the filled positions identified to each organization unit.~~
- ~~D. Allocate based on timesheets maintained by employees by benefiting facility. Employees record their effort on a daily basis. Effort is identified to investigative activities by benefiting facility. The total effort identified to investigative activities are allocated based on the distribution of Medicaid/Medicare/Other beds identified to the benefiting facilities. Dually certified beds (i.e., Medicaid/Medicare) will be distributed equally between the two programs. In the case of Skilled Medical Professionals, costs will be claimed at the enhanced rate of 75% FFP. Any effort identified to the general support of licensing and certification surveys will be allocated to the Licensing and Certification Section.~~
- E. Costs will be claimed in accordance with the *Health Facilities Licensing and Certification* Grant awarded by the Health Care Financing Administration (HCFA), USDHHS. Licensing and certification/survey effort associated with the grant award is supported by timesheets maintained by employees to record their effort on a daily basis. Effort is identified between licensing, certification/survey, and investigative activities by benefiting facility.
- F. Allocate to all licensed facilities using the distribution of Medicaid/Medicare/Other beds in the respective facilities. Dually certified beds (i.e., Medicaid/Medicare) will be distributed equally between the two programs.